# Update for Interpreters and Stakeholders

The 2014 Minnesota Legislature directed the Minnesota Department of Health (MDH) to develop recommendations to promote equitable access to health services for limited English proficient (LEP) Minnesotans. After gathering information and engaging many members of the interpreter community, MDH recommends a tiered registry system. This is a summary of our process and recommendations. The full report will be available in early 2015.

Currently there are no regulations in Minnesota that set minimum standards for health care interpreters. In 2009, Minnesota created a voluntary statewide roster for spoken language health care interpreters. There is a $50 annual roster fee. There are no credentials required to be listed on the roster, and MDH does not verify any of the information provided by interpreters. As of December 1, 2014, there are approximately 3,600 interpreters listed on the roster.

## Recommendations

***1. Establish a tiered registry system with four distinct tiers and verified qualifications***

- An entry-level tier with minimum qualifications. All interpreters, including those in higher tiers, must meet these entry-level requirements.
- Three higher tiers containing increasing qualifications. All three upper tiers require completion of continuing education for renewal.
- See attached guide for a draft of proposed tiers.

***2. Develop ethics and basic medical terminology exams in English for all interpreters***

***3. Expand MDH's website to better serve as a resource for interpreters and other stakeholders***

***4. Form an Advisory Council comprised of a broad range of stakeholders***

- The council will provide guidance and expertise to MDH and ensure the system is flexible and adapts to the changing field.

***5. Establish a means of investigation and enforcement consistent with state and federal laws***

## Key findings – What we heard from the community

***Quality standards:*** Minimum interpreter qualifications, such as understanding interpreter ethics, are necessary to ensure a baseline standard of care.

- The need for standards for all interpreters must be balanced with LEP patients' need for access to interpreters.
- Unverified information about an interpreter's qualifications and experience is not useful to people using interpreter services.

- Interpreters have a broad range of qualifications, skills, and experience. The system should allow for this range but show differences in qualification levels.
- Bilingual ability on its own does not qualify anyone to interpret. Interpreting skills, knowledge of medical terminology, and ethics are also necessary.

***Costs:*** Interpreters are concerned about current roster fees, the potential for future increases, and how fees are spent. MDH collects more in roster fees than is required to run the current program. MDH must receive legislative approval to spend surplus funds on interpreter initiatives. Stakeholders are concerned that regulation will result in additional costs to interpreters with no increase in their wage or income.

***Adaptability:*** The system must be flexible enough to meet the needs of interpreters of rare languages and must be able to adapt to future changes in interpreting.

***Complaints:*** The current system has no way to report or investigate complaints.

## Background information

***The Need for Interpreters.*** Nearly eleven percent of Minnesotans (ages 5 and older) speak a language other than English at home. An estimated 213,100 Minnesotans have a limited ability to speak, read, write, or understand English,[1] so they may not be able to understand health information in English. High-quality health care interpreting results in better health outcomes for LEP patients.[2] The lack of state standards for interpreter ethics, skills, and training has left Minnesota's LEP population at risk of worse health outcomes.

***Federal Guidance.*** Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, or national origin in programs and activities receiving any federal funding. Because of Title VI, health care providers must provide interpretation services to all LEP patients free of charge, so they have equal access to health care.

***Developments Outside of Minnesota.*** Certain states and organizations have established standards for health care interpreters. For example, two organizations now offer nationally-accredited certifications for interpreters. Codes of ethics and standards of practice have been accepted by the interpreting industry. In the process of creating our recommendations, MDH researched other states' and organizations' work on health care interpreting, as well as standards for interpreting in other fields.

## Engagement process

An important part of this project was making sure that all stakeholders were informed and encouraged to share their ideas. MDH identified and engaged a broad range of stakeholder individuals and groups in a variety of ways. We reached stakeholders through the interpreter roster, community groups, referrals from other contacts, and e-mail lists. Each e-mail and meeting invitation sent to stakeholders included a request to share the information with others.

[1] 2013 data from the American Community Survey undertaken by the U.S. Census Bureau.

[2] Australian College for Emergency Medicine. Resource list covering interpreters and language access barriers. https://www.acem.org.au/getmedia/d06a150a-8f9f-49f6-9647-eda5ac438af1/Module-4-Further-Learning-Resources.pdf.aspx

Throughout the process, we sent e-mail updates and updated the MDH interpreter website[3] to provide information on the project and encourage stakeholder involvement.

Contacts were invited to participate in individual and community meetings held in the Twin Cities, St. Cloud, and Rochester. We also invited experts in the interpreting field, and people who were involved with interpreter legislation in the past, to meet with MDH and share their knowledge as *key informants*. Additionally, we emailed, met, or spoke with all other individuals and groups that contacted us for information or requested the opportunity to provide input. Over 300 members of the interpreter community participated in these meetings.

MDH also invited all interpreters on the roster and all previously identified contacts to participate in a survey. A total of 468 individuals responded to the survey, 361 of whom had not participated in previous engagement opportunities. Data from the survey provide valuable insight into the diversity of viewpoints in the Minnesota interpreter community.

## Key stakeholder groups

- Interpreters
- Interpreter Organizations and Groups
- Educators and Trainers
- Interpreter Agencies
- Interpreter Services Departments within Health Systems
- Health Plans
- Health Care Providers and Local Public Health
- Community Organizations Representing LEP Populations
- National Certifying Bodies
- Key Informants
- Limited English Proficient Individuals
- Others Requesting Involvement



[3] http://www.health.state.mn.us/interpreters

## DRAFT Registry Guide – Spoken Language Health Care Interpreters

| Tier | Requirements |
|---|---|
| **Tier 1** | Minimum age of 18<br>**Plus:** Pass MDH Interpreter Ethics Test (Online)<br>**Plus:** Pass MDH Medical Terminology Test (Online)<br>→ **All interpreters** must fulfill these requirements* |
| **Tier 2** | **All Tier 1 requirements**<br>**Plus:** 4 hours of continuing education[1] per year<br>**Plus:** 40 hours of interpreter training through an approved training body[2]<br>(Requirement will change to 60 hour minimum on 1/1/2018) |
| **Tier 3** | **All Tier 1 requirements**<br>**Plus:** 6 hours of continuing education[1] per year<br>**Plus:** National certification in interpreting that **does not** include language proficiency component in the non-English language[3]<br>**Or:** Certificate in interpreting from an accredited US educational institution[5] |
| **Tier 4** | **All Tier 1 requirements**<br>**Plus:** 8 hours of continuing education[1] per year<br>**Plus:** National certification in interpreting that **does** include language proficiency component in the non-English language[4]<br>**Or:** National certification in interpreting that **does not** include language proficiency component in the non-English language[3]<br>**AND** Pass an oral proficiency exam[6] in non-English language<br>(Only available for interpreters of languages for which proficiency component does not exist at the time interpreter seeks certification)<br>**Or:** Associate's Degree or greater in interpreting from an accredited US institution[5]<br>(60 or more semester credits with internship or experience component) |

**Preapproved options to fulfill requirements^**

**1. Continuing education accredited by**
-American Translators Association (ATA)
-International Medical Interpreters Association (IMIA)
-Certification Commission for Healthcare Interpreters (CCHI)

**2. Interpreter training (40+ hours)**
-Bridging the Gap
-The Community Interpreter
-Language Access Consulting and Training

**3. National certification in interpreting (No language proficiency component)**
-CoreCHI from CCHI

**4. National certification in interpreting (Including language proficiency component)**
-Certified Medical Interpreter (CMI) from National Board of Certification for Medical Interpreters (NBCMI)
-Certified Healthcare Interpreter (CHI) from CCHI

**5. Educational institution**
-Century College
-University of Minnesota
-All accredited US institutions
-Foreign institutions as approved by Advisory Council

**6. Oral proficiency exam**
-American Council on the Teaching of Foreign Languages (ACTFL) →Score of Advanced Mid or greater

***All interpreters including those located outside of Minnesota** whose services are used for LEP individuals in Minnesota must be at least a Tier 1 member
→Or fulfill equivalent as verified through language services provider

^Other options will be evaluated as necessary by the Advisory Council

# DRAFT Legislative Guide – Options for Spoken Language Health Care Interpreter Registry Program

**The Legislature can select and combine program functions to build a regulatory system for spoken language health care interpreters. The functions selected determine the amount of the fees. The fees necessary to fund each function are shown in the columns on the right.**

| Program Function | Description of Program Function | Contribution to Fee | | |
|---|---|---|---|---|
| | | Tier 1 | Tier 2 | Tier 3 & Tier 4 |
| **Regulation** | • Verify that applicants have passed ethics and medical terminology tests<br>• Verify that applicants have provided adequate documentation of qualification for Tiers 2, 3, or 4<br>• Ongoing IT support for online application system<br>• This does NOT include technical assistance to interpreters in applying to the registry | $33.00 | $56.00 | $73.00 |
| **Technical Assistance** | • Assist registry applicants in understanding qualifications for each tier<br>• Assist registry applicants in completing application process | $8.00 | $8.00 | $8.00 |
| **Advisory Council** | • Advise MDH on issues relating to interpreting skills, standards of practice, and ethics<br>• Inform MDH of emerging issues in the field<br>• Provide consultation on need to draft and request legislative changes to interpreter law | $10.00 | $10.00 | $10.00 |
| **Complaints & Oversight** | **Two options:** | | | |
| **Option 1: Complaint & Advisement** | • Accept complaints and send letters of advisement , there is NO investigation<br>  ○ Interpreters are informed that there has been a complaint, told the nature of the complaint, and referred to appropriate ethical standards or standards of practice<br>• Instances of fraud, abuse, and coercion are referred to local law enforcement | $11.00 | $11.00 | $11.00 |
| **Option 2: Investigation & Enforcement** | • Accept and investigate complaints; obtain translation and interpretation where necessary to read complaints and interview witnesses<br>  ○ Bring enforcement action (fines, remedial action, or remove from registry) against interpreters where complaints are substantiated | $46.00 | $46.00 | $46.00 |
| **Start-Up Costs** | • Complete computer programming to expand data collected<br>• Allow online administration and result reporting of ethics and legal terminology tests<br>• Allow attachment and transmittal of supporting documentation<br>• Provide application status reports to applicants<br>• Develop ethics and legal terminology tests<br>• Support staffing to plan and create regulatory infrastructure | Approximate one time start-up costs:<br>• $478,000, FY16<br>• $95,000, FY17<br>• $73,000, FY18 | | |

**The examples below assume start-up costs will be funded by non-fee sources. Fee amounts would replace the existing fee under current law.**

| Registry System | Program Functions Included | Total Fee | | |
|---|---|---|---|---|
| | | Tier 1 | Tier 2 | Tier 3 & Tier 4 |
| **1. Minimal System** | Regulation + Option 1: Complaint & Advisement | **$44.00** | **$67.00** | **$84.00** |
| **2. Basic System** | Regulation + Technical Assistance + Advisory Council + Option 1: Complaint & Advisement | **$62.00** | **$85.00** | **$102.00** |
| **3. Comprehensive Regulatory Program** | Regulation + Technical Assistance + Advisory Council + Option 2: Investigation & Enforcement | **$97.00** | **$120.00** | **$137.00** |

For example: if the "Basic System" were enacted by the Legislature at these rates, a Tier 1 interpreter would pay $62.00.